MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between Maryland Collaborative Care Transformation Organization, LLC, a care transformation organization (the "CTO"), and [name of Practice], (the "Practice") (each a "Party," and collectively the "Parties").

The CTO has been selected by the Centers for Medicare and Medicaid Services ("CMS"), Center for Medicare and Medicaid Innovation ("CMMI"), to serve as a care transformation organization in the Maryland Primary Care Program ("MDPCP"). The Practice is a primary care practice that provides health care services to Medicare beneficiaries, among others, in the State of Maryland.

This Arrangement sets forth the terms and conditions under which the CTO will provide to the Practice certain care transformation services and resources consistent with MDPCP requirements.

1. *Participation Agreements*. Prior to the Effective Date of this Arrangement, the CTO must sign an MDPCP Participation Agreement with CMMI (the "CTO Participation Agreement"). Prior to the Effective Date of this Arrangement, the Practice must sign an MDPCP Participation Agreement with CMMI (the "Practice Participation Agreement"). If either Party does not sign a Participation Agreement with CMMI prior to the Effective Date of this Arrangement, then this Arrangement shall be deemed null ab initio.

2. *Effective Date*. The Effective Date of this Arrangement is the later of January 1, 2019, or January 1 of the year following the date this Arrangement is signed by the last Party to sign it (as indicated by the date associated with that Party's signature). A Party's performance obligations under this Arrangement shall not begin prior to the Effective Date.

3. *Term of Arrangement*. This Arrangement is effective for a minimum of one full Performance Year, which consists of a 12-month period beginning on January 1 of each year, and will renew automatically on January 1 of each year, until terminated by either party in accordance with Section 12 of this Arrangement. This Arrangement is subject to early termination by either Party only if: (1) CMS terminates either the CTO Participation Agreement or the Practice Participation Agreement, or (2) if CMS authorizes, in writing, such early termination of this Arrangement.

4. *Offer and Selection of CTO Services*. The Practice is responsible for meeting the Care Transformation Requirements as listed in Appendix A. The CTO will support the Practice in meeting those requirements including any support specified in the either the CTO or Practice Participation Agreements. The CTO has offered to provide any and all of the CTO Services to the Practice, as listed in the package selected in Appendix B. The CTO offers these same CTO Services to all participating practices within the same service option level and Track.

5. *Care Management Fees*. CMS will calculate the Practice's Care Management Fees ("CMF") according to the CTO Participation Agreement, the Practice Participation Agreement, and the methodologies described therein. In accordance with CTO Option Selection Form A, the CTO will receive **30/50%** of the practice's CMF payment amount calculated by CMS, and the remaining **70/50%** of such CMF payment amount will be paid to the Practice.

6. *Lead Care Manager*. For practices choosing the 50% option, the CTO will provide the Practice with one or more individuals who are fully dedicated to care management functions of the Practice (the "Lead Care Manager"), and additional services selected in accordance with Section 4. For practices choosing the 30% option, the practice will have its own care manager(s) to work in conjunction with the CTO and the CTO's offerings in accordance with Section 4.

7. *Data Sharing and Privacy*. The Practice authorizes the CTO to have access to all clinical data available in the electronic medical records or shared through the State-Designated Health Information Exchange ("HIE"), including personal health information, of MDPCP Beneficiaries attributed to the Practice. The Practice authorizes the CTO to have access via CRISP to quality and utilization reports available to the Practice. The CTO will include a Business Associate Agreement ("BAA") for the Practice to approve. The BAA will govern their data sharing, use, and confidentiality, a copy of which is in Appendix B. Each Party will comply with HIE policies and regulations, including patient education requirements, and will execute any separate agreement that may be required by CRISP.

8. *Notification of Changes in Medicare Enrollment*. The Practice will notify the CTO of any changes to the Practice's Medicare beneficiary enrollment information within thirty (30) days after such changes occur.

9. *No Remuneration Provided*. Neither the CTO nor the Practice has offered, given, or received remuneration in return for, or to induce business other than the business covered under this CTO Arrangement.

10. *Practice of Medicine or Professional Services Not Limited by this Arrangement*. The Arrangement does not limit or restrict in any way the ability of the Practice and its clinician(s) to make medical decisions that they consider in their professional judgment to be in the best interest of a MDPCP Beneficiary.

11. *Compliance with All Applicable Laws*. This Arrangement does not alter or amend the Parties' being bound to comply with all relevant federal and State laws, including, but not limited to, health care fraud and abuse laws, HIPAA, and the Maryland Medical Practice Act. The CTO will continue to be bound by the terms of the CTO Participation Agreement, and the Practice will continue to be bound by the terms of the Practice Participation Agreement.

12. *Termination*. Either Party may terminate this Arrangement annually or earlier by providing written notice of termination to the other Party, CMS and the Program Management Office. If the Practice or CTO decides to terminate this Arrangement for any reason, it must provide written notice in accordance with the notification and termination requirements stated in the applicable MDPCP Participation Agreements. This Arrangement automatically terminates on the Effective Date of the termination of either the CTO Participation Agreement or the Practice Participation Agreement.

13. *Copies and Retention of Arrangement*. The Practice will provide a copy of this Arrangement to the CTO and the Maryland Department of Health, Program Management Office, within thirty (30) days of execution. The CTO will retain copies of this Arrangement for a period of ten (10) years following expiration or termination of the CTO Participation Agreement. The CTO will, upon request, provide copies of this Arrangement to the federal government, including, but not limited to, CMS, the HHS Office of the Inspector General, or the Comptroller General.

14. *Amendments*. The Parties may amend this Arrangement including, but not limited to, the CTO Services offered and provided, at any time upon mutual written consent. The CTO must continue to offer the same CTO Services to all participating practices within the same service option level and Track, as specified in Section 4 of this Arrangement.

IN WITNESS THEREOF, and in acknowledgement of the aforementioned, the authorized representatives of the CTO and the Practice do hereby indicate their approval and consent:

FOR THE CARE TRANSFORMATION ORGANIZATION:

__SAMPLE Only – Do NOT Complete Now___
Signature

__SAMPLE Only – Do NOT Complete Now___
Printed Name

__SAMPLE Only – Do NOT Complete Now___
MDPCP CTO ID

__SAMPLE Only – Do NOT Complete Now___
Title

__SAMPLE Only – Do NOT Complete Now___
Date Signed

FOR THE PRACTICE:

__SAMPLE Only – Do NOT Complete Now___
Signature

__SAMPLE Only – Do NOT Complete Now___
Printed Name

__SAMPLE Only – Do NOT Complete Now___
MDPCP Practice ID

__SAMPLE Only – Do NOT Complete Now___
Title

__SAMPLE Only – Do NOT Complete Now___
Date Signed

Appendix A:

Care Transformation Requirements

Comprehensive Primary Care Functions of Advanced Primary Care	Care Transformation Requirement	Practice Track Requirement
Access and Continuity	1.1 Empanel attributed beneficiaries to practitioner or care team.	Track 1 + 2
	1.2 Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.	Track 1 + 2
	1.3 Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.	Track 2 only
Care Management	2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.	Track 1 + 2
	2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.	Track 1 + 2
	2.3 Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.	Track 1 + 2
	2.4 Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering events receive short-term (episodic) care management.	Track 1 + 2
	2.5 Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.	Track 2 only
	2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.	Track 2 only
Comprehensiveness and Coordination across the Continuum of Care	3.1 Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.	Track 1 + 2
	3.2 Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the Practice	Track 1 + 2
	3.3 Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs	Track 2 only
Beneficiary & Caregiver Experience	4.1 Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.	Track 1 + 2
	4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning	Track 2 only
Planned Care for Health Outcomes	5.1 Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.	Track 1 + 2

Appendix B:
CTO Services/Personnel Offered and Practice Selection

Track 1 Package A (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Access to our Behavioral Health Integration partners which will assist in establishing a primary behaviorist model for the practice. In addition, we provide access to the remote Wellcare Behavioral Health team and a 24/7 Behavioral Health care line.	Behavioral Care Manager, RN Regional Social worker Quality Practice Advisor, RN	1 per 15 practices 1 per 20 practices 1 per 5 practice
Medication Management	Care Management 2.6	Access to our robust Medication Management vendor partner. In addition, Our case management team will perform a medication review and reconciliation for all patients in care to management to identify interventions. We refer to our remote team of Wellcare pharmacist for intervention plans.	Pharmacy Tech (RpH) Care Manager, RN Telephonic Medication Management line	1 per 20 practices 1 per 5 practice All practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Services Beyond Healthcare: Through WellCare Community Connections, you can connect to a wide range of services that help you live a better, healthier life.	Peer Coaches Community Care line	1 per 5 practices All practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Access to a care manager who will perform home assessment visits, although not a requirement of track 1.	Care Manager, RN	1 per 5 practice
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Identify patients being discharged from hospital and ED. Initiate the non-face to face portion of transitional Care visit. Educate and train office staff on workflow and billing of TCM	Care Manager, RN Telephonic Care Coordinators	1 per 5 practice 1 per 15 practice
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Identify, initiate and completed a care plan in collaboration with patient and /or caregiver for all Complex to high risk patients using the risk stratification tool.	Care Manager, RN	1 per 5 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provide education and training on the quality measures. Review and initiate set up of Electronic Health Record eCQMs dashboard	Quality Practice Advisor Market Manger program Operations Pop health Data Analytical team	1 per 5 practice All practices All practices

Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Provide data analysis to help meet the care transformation requirements. We offer a health IT system to help promote effective strategy for treatment planning and monitoring health outcomes	Population health Analytical team	All practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provider guideline tools for engaging beneficiaries and caregivers to ensure optimal care delivery. Identify areas to engage beneficiaries in goal setting and shared decision-making	Quality practice Advisor	1 per 5 practice
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Help identify and close gaps in the at risk population. Will apply evidence based protocols for screening and treatment.	Quality Practice Advisor	1 per 5 practice
24/7 Access	Access & Continuity 1.2	Assist with establishment, and provider access to our Wellcare nurse line and BH crisis line	Nurse Line	All practices
Referral Management	Comprehensiveness & Coordination 3.1	Collaborate with practice to identify, coordinate and provider alternate interventions for referral management. Especially for from high-volume and/or high-cost specialists as well as EDs and hospitals.	Quality Practice Advisor	1 per 5 practice

Track 2 Package B (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Access to our Behavioral Health Integration partners which will assist in establishing a primary behaviorist model for the practice. Our partners can integrate, collocate or referral to a list of resources, psychiatrists, BH specialist and facility In addition, we provide access to the remote Wellcare Behavioral Health team and a 24/7 Behavioral Health care line.	Behavioral Care Manager, RN Regional Social worker Quality Practice Advisor, RN	1 per 15 practices 1 per 20 practices 1 per 5 practice
Medication Management	Care Management 2.6	Access to our robust Medication Management vendor partner. In addition, Our case management team will perform a medication review and reconciliation for all patients in care to management to identify interventions. We refer to our remote team of Wellcare pharmacist for intervention plans.	Pharmacy Tech (RpH) Care Manager, RN Telephonic Medication Management line	1 per 20 practices 1 per 5 practices All practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Services Beyond Healthcare: Through WellCare Community Connections, you can connect to a wide range of services that help you live a better, healthier life.	Peer Coaches Community Care line	1 per 5 practice All practice
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Access to a health technology that is enabled to perform telehealth. In addition and a care manager who will perform home assessment visits	Care Manager, RN	1 per 5 practice
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Identify patients being discharged from hospital and ED. Initiate the non-face to face portion of transitional Care visit. Educate and train office staff on workflow and billing of TCM	Care Manager, RN Telephonic Care Coordinators	1 per 5 practice 1 per 15 practice
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Identify, initiate and completed a care plan in collaboration with patient and / or caregiver for all Complex to high risk patients using the risk stratification tool.	Care Manager, RN	1 per 5 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provide education and training on the quality measures. Review and initiate set up of Electronic Health Record eCQMs dashboard	Quality Practice Advisor Market Manger program Operations Pop health Data Analytical team	1 per 5 practice All practices All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Provide data analysis to help meet the care transformation requirements. We offer a health IT system to help promote effective strategy for treatment planning and monitoring health outcomes	Population health Analytical team	All practices

Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provider guideline tools for engaging beneficiaries and caregivers to ensure optimal care delivery. Identify areas to engage beneficiaries in goal setting and shared decision-making	Quality practice Advisor	1 per 5 practice
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Help identify and close gaps in care for the at-risk population. Will apply evidence based protocols for screening and treatment.	Quality Practice Advisor Market Manger program Operations Pop health Data Analytical team	1 per 5 practice All practices All practices
24/7 Access	Access & Continuity 1.2	Assist with establishment of 24/7 access, and provider access to our Wellcare nurse line and BH crisis line	Nurse Line	All practices
Referral Management	Comprehensiveness & Coordination 3.1	Collaborate with practice to identify, coordinate and provider alternate interventions for referral management. Especially for from high-volume and/or high-cost specialists as well as EDs and hospitals.	Quality Practice Advisor	1 per 5 practice

Track 1 Package C (30%)*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Train practice BH specialist on care coordination. Provider community resource connections to the practice specialist.	Quality Practice Advisor	1 per 10 practice
Medication Management	Care Management 2.6	N/A	N/A	N/A
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Services Beyond Healthcare: Through WellCare Community Connections, you can connect to a wide range of services that help you live a better, healthier life.	Community Care line	All practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	N/A.	N/A	N/A
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	N/A	N/A	N
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	N/A	N/A	N/A
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provide education and training on the quality measures. Review and initiate set up of Electronic Health Record eCQMs dashboard	Quality Practice Advisor Market Manger program Operations Pop health Data Analytical team	1 per 10 practice All practices All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Coach staff on interpretation and utilization of data to help derive evidence base intervention on high risk population.	Quality Practice Advisor	1 per 10 practice
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Educate practice staff on developing protocols on engaging signed beneficiaries	Quality Practice Advisor	1 per 10 practice
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Guide practice to identify and close gaps in care for at risk population	Quality Practice Advisor	1 per 10 practice
24/7 Access	Access & Continuity 1.2	N/ A	N/A	N/A
Referral Management	Comprehensiveness & Coordination 3.1	Coach practices to identify, coordinate and find alternate interventions for referral management. Especially for from high-volume and/or high-cost specialists as well as EDs and hospitals.	Quality Practice Advisor	1 per 10 practice

*Practice will have its own care manager to work in conjunction with the CTO and the CTO's offerings.

Track 2 Package D (30%)*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Train practice BH specialist on care coordination. Provider community resource connections to the practice specialist.	Quality Practice Advisor	1 per 10 practice
Medication Management	Care Management 2.6	Access to our remote team of Wellcare pharmacist for intervention protocols.	Telephonic Medication Management line	All practice
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Services Beyond Healthcare: Through WellCare Community Connections, you can connect to a wide range of services that help you live a better, healthier life.	Community Care line	All practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Help coach and establish telehealth workflows within practice.	Quality Practice Advisor	1 per 10 practice
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	N/A	N/A	N
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	N/A	N/A	N/A
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provide education and training on the quality measures. Review and initiate set up of Electronic Health Record eCQMs dashboard	Quality Practice Advisor Market Manger program Operations Pop health Data Analytical team	1 per 10 practice All practices All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Coach staff on interpretation and utilization of data to help derive evidence base intervention on high risk population.	Quality Practice Advisor	1 per 10 practice
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Educate practice staff on developing protocols on engaging signed beneficiaries	Quality Practice Advisor	1 per 10 practice
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Guide practice to identify and close gaps in care for at risk population	Quality Practice Advisor	1 per 10 practice
24/7 Access	Access & Continuity 1.2	N/ A	N/A	N/A
Referral Management	Comprehensiveness & Coordination 3.1	Coach practices to identify, coordinate and find alternate interventions for referral management. Especially for from high-volume and/or high-cost specialists as well as EDs and hospitals.	Quality Practice Advisor	1 per 10 practice

*Practice will have its own care manager to work in conjunction with the CTO and the CTO's offerings.

Final Practice Selection

- ☐ Package A Track 1 (50%)
- ☐ Package B Track 2 (50%)
- ☐ Package C Track 1 (30%)
- ☐ Package D Track 2 (30%)

Practice Signature SAMPLE Only – Do NOT Complete Now CTO Signature SAMPLE Only – Do NOT Complete Now

Appendix C:

Business Associate Agreement
Between the CTO and the Practice

[Attached hereto]